House of Representatives

General Assembly

File No. 173

February Session, 2016

Substitute House Bill No. 5230

House of Representatives, March 24, 2016

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR FERTILITY PRESERVATION FOR INSUREDS DIAGNOSED WITH CANCER.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2017*) (a) (1) Subject to the limitations set forth in subsection (b) of this section and except as provided in subsection (c) of this section, each individual health insurance policy providing coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for embryo, oocyte and sperm cryopreservation procedures, in accordance with guidelines established by the American Society of Clinical Oncology, for an insured who is at least eighteen years of age and has been diagnosed with cancer but has not started cancer treatment, including chemotherapy, biotherapy or radiation therapy treatment.

(2) The coverage required under this section shall include expenses

for evaluations, laboratory assessments, medications and treatments associated with the embryo, oocyte and sperm cryopreservation procedures, but shall not include costs for initial or annual storage of embryos, oocytes or sperm.

(b) Such policy may:

(1) Limit such coverage to an individual until the date of such individual's fortieth birthday;

(2) Limit such coverage for a female insured to a lifetime benefit of one procedure for either embryo cryopreservation or oocyte cryopreservation; and

(3) Limit such coverage for a male insured to a lifetime benefit of one sperm cryopreservation procedure.

(c) (1) Any insurance company, hospital service corporation, medical service corporation or health care center may issue an individual health insurance policy that excludes coverage for embryo, oocyte and sperm cryopreservation procedures that are contrary to an individual's bona fide religious tenets.

(2) Upon the written request of an individual who states in writing that methods of embryo, oocyte and sperm cryopreservation procedures are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods.

(3) Any health insurance policy issued pursuant to this subsection shall provide written notice to each insured or prospective insured that coverage for embryo, oocyte and sperm cryopreservation procedures are excluded from coverage pursuant to this subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

Sec. 2. (NEW) (*Effective January 1, 2017*) (a) (1) Subject to the limitations set forth in subsection (b) of this section and except as provided in subsection (c) of this section, each group health insurance policy providing coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for embryo, oocyte and sperm cryopreservation procedures, in accordance with guidelines established by the American Society of Clinical Oncology, for an insured who is at least eighteen years of age and has been diagnosed with cancer but has not started cancer treatment, including chemotherapy, biotherapy or radiation therapy treatment.

(2) The coverage required under this section shall include expenses for evaluations, laboratory assessments, medications and treatments associated with the embryo, oocyte and sperm cryopreservation procedures, but shall not include costs for initial or annual storage of embryos, oocytes or sperm.

(b) Such policy may:

(1) Limit such coverage to an individual until the date of such individual's fortieth birthday;

(2) Limit such coverage for a female insured to a lifetime benefit of one procedure for either embryo cryopreservation or oocyte cryopreservation; and

(3) Limit such coverage for a male insured to a lifetime benefit of one sperm cryopreservation procedure.

(c) (1) Any insurance company, hospital service corporation, medical service corporation or health care center may issue to a religious employer a group health insurance policy that excludes coverage for embryo, oocyte and sperm cryopreservation procedures that are contrary to the religious employer's bona fide religious tenets.

(2) Upon the written request of a religious employer that states in

writing that methods of embryo, oocyte and sperm cryopreservation procedures are contrary to such employer's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the religious employer a policy or rider thereto that excludes coverage for such methods.

(3) Any health insurance policy issued pursuant to this subsection shall provide written notice to each insured or prospective insured that coverage for embryo, oocyte and sperm cryopreservation procedures are excluded from coverage pursuant to this subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

(4) As used in this subsection, "religious employer" means an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2017*	New section
Sec. 2	*January 1, 2017*	New section

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 17 $	FY 18 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health Accounts)	GF&TF - Cost	$60,000 – Up to $1.6 million	$118,000 – Up to $3.2 million
The State	Uncertain - Cost	$41,000 – Up to $1.1 million	$82,000 – Up to $2.2 million

Note: GF&TF=General Fund & Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 17 $	FY 18 $
Various Municipalities	STATE MANDATE - Cost	$45,000 – Up to $1.2 million	$90,000 – Up to $2.4 million

Explanation

The bill will result in a cost to the state employee and retiree health plan[1], municipalities, and the state, for providing coverage for cryopreservation procedures and all associated treatment for individuals 18 and older who have been diagnosed with cancer but who have not undergone treatment.[2] The total estimated cost to the state in FY 17 is between approximately $100,000 and $2.7 million and

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

[2] The state plan currently provides coverage for medically necessary infertility diagnosis and treatment, and currently excludes cryopreservation procedures. Current infertility treatment involving outpatient or inpatient procedures are covered with no cost sharing for members enrolled in the Health Enhancement Program (HEP); standard office visit copay applies for office visits. Non-HEP members must satisfy plan deductibles. Members enrolled in point of service plans who utilize out of network providers must satisfy the plan deductible and coinsurance.

between approximately $200,000 and $5.4 million in FY 18. This cost is attributable to (1) the estimated cost to the state plan in FY 17 of between $60,000 and $1.6 million and between $118,000 and $3.2 million in FY 18 and (2) the cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) in FY 17 of between $41,000 to $1.1 million and between $82,000 and $2.2 million in FY 18. The cost to fully insured municipalities in FY 17 is between $45,000 to $1.2 million in FY 17 and between $90,000 and $2.4 million in FY 18.[3]

If adopted by the state plan, the actual cost to the plan will depend on the cost of services, the utilization of services by the plan's population, and the amount of member cost sharing. Lastly, the bill allows the following policy limits: (1) coverage for people under the age of 40, and (2) a lifetime limit of one procedure. These limits and any member cost sharing imposed by plans may mitigate the estimated cost to the state plan, the state under the ACA, and municipalities.

Municipal Impact

As previously stated, the bill will increase costs to certain fully insured, municipal plans that do not currently provide coverage for cryopreservation in accordance with the bill. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2017. In addition, many municipal health plans are recognized as "grandfathered" health plans under the ACA.[4] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant

[3] The estimated cost for municipalities is based on Dept. of Labor employment information as of January 2016 and the estimated state impact is based on exchange enrollment as of February 2016. Exchange enrollment excludes Medicaid enrollees. The estimated cost for the state employee plan is based on the plan's under 65 membership as of February 2016. The range in cost is based on PMPM estimates of $.059 PMPM (which may be understated as the 2013 estimate has not been adjusted for potential growth in procedure costs over time (*UCONN, 2013*)) and an average of $1.60 PMPM provided by the state's health carriers.

[4] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

to federal law, self-insured health plans are exempt from state health mandates.

The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)[5], include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan[6] to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. Absent further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan.[7] However, neither the agency nor the mechanism for the state to pay these costs has been established.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to (1) medical inflation, (2) the number of covered lives in the state, municipal and exchange health plans, and (3) the utilization of services.

Sources: *Department of Labor*
Office of the State Comptroller
Office of the State Comptroller State Health Plan, Health Benefit Document as of January 2015
University of Connecticut Center for Public Health and Health Policy Review and Evaluation of Certain Health Benefit Mandates in Connecticut, 2013 (REVISED)

[5] The state's health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.
[6] The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.
[7] *Source*: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

OLR Bill Analysis

sHB 5230

AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR FERTILITY PRESERVATION FOR INSUREDS DIAGNOSED WITH CANCER.

SUMMARY:

This bill requires certain health insurance policies to cover embryo, oocyte, and sperm cryopreservation procedures for insured people who are at least age 18 and diagnosed with cancer but have not started cancer treatment (e.g., chemotherapy, biotherapy, or radiation). But it allows religious employers and individuals to exclude this coverage from their policies if it is contrary to their religious tenets.

Under the bill, covered cryopreservation procedures must be in accordance with the American Society of Clinical Oncology's guidelines. The policies must (1) cover cryopreservation-related evaluations, laboratory assessments, medications, and treatments and (2) exclude coverage for storing embryos, oocytes, and sperm. The bill also allows a policy to limit cryopreservation coverage to (1) people under age 40 and (2) one procedure per lifetime (i.e., one embryo or oocyte cryopreservation procedure per female and one sperm cryopreservation procedure per male).

EFFECTIVE DATE: January 1, 2017

APPLICABILITY

The bill applies to group and individual health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided by an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance

benefit mandates do not apply to self-insured benefit plans.

RELGIOUS EXEMPTION

The bill allows an insurer, hospital or medical service corporation, or HMO ("company") to issue a religious employer or individual a health insurance policy or rider that excludes cryopreservation coverage if the employer or individual notifies the company in writing that cryopreservation procedures are contrary to their religious or moral beliefs.

A company that excludes the coverage from a policy because of a religious exemption must give written notice of the exclusion to each insured or prospective insured. The notice must be in at least 10-point type and appear in the policy, application, and sales brochure.

Under the bill, a "religious employer" is a qualified church-controlled organization, as defined in federal law, or a church-affiliated organization. A "qualified church-controlled organization" is a church-controlled tax-exempt organization, other than one that (1) offers goods, services, or facilities for sale to the general public, unless sold at a nominal charge that is substantially less than the actual cost, and (2) normally receives more than 25% of its support from either the government or receipts from certain admissions, merchandise sales, services performed, or facilities furnished (26 U.S.C. § 3121).

BACKGROUND

Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required "essential health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to state benefit mandates enacted after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefit it mandates after that date.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 15 Nay 3 (03/11/2016)